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## 13132

13158

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELTON THOMAS ADKINS</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>29th</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 23, 1902</b>
9. AGE (In years lost birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter - House Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>George Irving Adkins</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Jane Mills</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mrs. Margie Adkins (Wife)</b> Address <b>R.D.# 4 Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> <b>42-2-2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic myocarditis</b> (c) <b>Thrombotic internal hemorrhoids</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>N/A</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) <b>N/A</b>		20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
20f. (City or town) <b>N/A</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-26</b> , to <b>11-29</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>11-28</b> , 19 <b>60</b> , and that death occurred at <b>11-29</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Philip A. Insley</b>		22b. DATE SIGNED <b>Nov. 29/1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley</b>		22d. ADDRESS <b>Main St. Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Dec. 2, 1960</b>		23b. DATE THEREOF <b>Dec. 2, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>DEC 1 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		25c. ADDRESS <b>SALISBURY MARYLAND</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13159

13133

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>A</u> Last <u>Allen</u>				4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-9-1897</u>	
9. AGE (In years lost birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ISMA AURE</u>				14. MOTHER'S MAIDEN NAME <u>JENNIE ADASSEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>Mrs. Jack Allen, Newark, Md - Rt #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Collective Heart Failure</u> <u>416X</u> DUE TO <u>Chronic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cuppen. &amp; I. Bleeding</u> DUE TO <u>Gastric Ca.</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11-6</u> <u>1960</u> to <u>11-16</u> <u>1960</u> that (I) (we) last saw the deceased alive on <u>11-16</u> <u>1960</u> and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Francis Oden</u>				22b. DATE SIGNED <u>11-16-60</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>P. G. H. Salisbury, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>11-19-60</u>		<u>EVERGREEN Cem.</u>		<u>BERLIN, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley</u>				ADDRESS <u>Salisbury, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 28 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13135

13161

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>4 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Centenary Dr.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>ALLEN</b> Last <b>BAILEY</b>		4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 4, 1871</b>
9. AGE (In years lost birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seafood, Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail &amp; Wholesale</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Oliver B ailey</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Marsch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Glendon Bailey</b>		Address <b>Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic</b> DUE TO <b>Chronic Pyelonephritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Pyelonephritis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> , 19 to <b>18 Nov</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>17 Nov</b> , 19 <b>60</b> and that death occurred at <b>10</b> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Earl L. Royer</b>		22b. DATE SIGNED <b>11-19-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Earl L. Royer</b>		22d. ADDRESS <b>407 Camden Ave., Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>NOV. 20. 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Church Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>MT. Vernon, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co.</b>		25a. REC'D BY REGISTRAR <b>NOV 22 '60</b>	
ADDRESS <b>Salisbury, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Colleen L. Hines</b>	

*George C. Hill*

13185

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13136

13162

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingston</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Box 66</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>FRANKLIN</u> Middle <u>Ballard</u> Last <u>Ballard</u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>7</u> Year <u>1960</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Aug. 3, 1960</u>	<b>9. AGE</b> (In years last birthday) <u>0</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>3</u> Days <u>1</u> <b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u></u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u></u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Kingston</u>
<b>13. FATHER'S NAME</b> <u>Charles Ballard</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Shirley Boston</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		<b>16. SOCIAL SECURITY NO.</b> <u></u> <b>17. INFORMANT</b> <u>Shirley Ballard-Marion Sta., Md.</u> Address <u></u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metabolic Acidosis</u> 571.0 DUE TO <u>Dehydration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Enterocolitis</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition</u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 weeks</u>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u>	<b>20f. (City or town) (County) (State)</b> <u></u>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>10/30</u> <u>1960</u> <b>to</b> <u>11/7</u> <u>1960</u> <b>that (I) (we) lost</b> <u></u> <b>saw the deceased alive on</b> <u>11/7</u> <u>1960</u> <b>and that death occurred on</b> <u>11/7</u> <u>1960</u> <b>at</b> <u>2:15 P.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Alfred C. Kolls</u> M.D. <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u></u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u></u>		<b>22d. ADDRESS</b> <u>Medical Center, Salisbury, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>11/5/60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u></u>	<b>23d. LOCATION (City, town, or county) (State)</b> <u>Marion Sta. Som. Co., Md.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Norma J. Ward</u> <b>ADDRESS</b> <u>Marion Station, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u></u> <b>DATE</b> <u>NOV 15 '60</u>	<b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Thomas</u>

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ALL INFORMATION CONTAINED  
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*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "The", "and", "of" are faintly visible.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9-59

13164

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13138

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u> First Middle Last				4. DATE OF DEATH <u>NOVEMBER 6</u> 19 <u>60</u> Month Day Year					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 5, 1960</u>			
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>2</u> <u>52</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>MARGIE BENNETT</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)					
17. INFORMANT <u>JAMES Phoebeus, DELMAR Rd., SALISBURY, Md.</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> 761-5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>PREMATURE SEPARATION PLACENTA</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>11-5-1960</u> to <u>11-6-1960</u> , that (I) (we) last saw the deceased alive on <u>11-6-1960</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert Lee Baker</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-6-60</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>SALISBURY, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-6-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park</u>		23d. LOCATION (City, town, or county) (State) <u>SALISBURY, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Wallace</u> ADDRESS <u>Salisbury, Md.</u>				25a. REC'D BY REGISTRAR <u>NOV 9 '60</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
13165 CERTIFICATE OF DEATH 13139										
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>					d. STREET ADDRESS <u>Delmar Road</u>					
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>BENNETT</u> Last <u>BENNETT</u>					4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>6</u> Year <u>1960</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 5, 1960</u>		9. AGE (In years last birthday) yrs. <u>2</u> Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>UNKNOWN</u>					14. MOTHER'S MAIDEN NAME <u>MARGIE BENNETT</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>JANES Phoebe, Delmar Rd, Salisbury, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURE SEPARATION PLACENTA</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11-5-</u> 19 <u>60</u> , to <u>11-6-</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11-6-</u> 19 <u>60</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>Robert Lee Baker</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-6-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert Lee Baker</u>					22d. ADDRESS <u>SALISBURY, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-6-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park</u>		23d. LOCATION (City, town, or county) (State) <u>SALISBURY Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas F. Sullivan</u>					ADDRESS <u>Salisbury, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 9 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

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1. The following is a list of the items which are to be included in the estimate of lead for the year 1964:

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13219  
13140  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Railroad Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>OLIVE</b> Middle <b>ROSE</b> Last <b>BENNETT</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>26</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 7, 1892</b>	
9. AGE (In years lost birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Athol, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>William Henry Budd</b>				14. MOTHER'S MAIDEN NAME <b>Emily Jackson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				17. INFORMANT <b>Mrs. Irene Hitchens (Daughter)</b> Address <b>R.D.# 5 (Parsons Road) Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Hour o. m. <b>N/A</b> Month <b></b> Day <b>19</b> Year <b></b> p. m. <b></b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
20f. (City or town) <b>N/A</b>				20g. (County) <b>N/A</b>		20h. (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>6/29</b> <b>19 59</b> , to <b>Death</b> <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>4:00 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Ernest M. Larmore</b>				22b. DATE SIGNED <b>Nov. 28/1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Ernest M. Larmore</b>				22d. ADDRESS <b>Delmar, Delaware</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 29, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mardela Cemetery (Old Part)</b>		23d. LOCATION (City, town, or county) (State) <b>Mardela, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>			
25a. REC'D BY REGISTRAR <b>DATE DEC 1 '60</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			



13166

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WICOMICO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. LENGTH OF STAY IN 1b <b>3 WKS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 SALISBURY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PENINSULA GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>1429 Somerset</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CORA</b>		First <b>REBECCA</b>		Last <b>BOOTH</b>		4. DATE OF DEATH Month <b>NOVEMBER</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 28, 1874</b>	
9. AGE (In years last birthday) <b>86</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN S. Jones</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA White</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Geo. Booth, Salisbury, Md.</b>		Address <b>Salisbury, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Artery Thrombosis</b> DUE TO (b) <b>Coronary Atherosclerosis</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>19 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/28/60</b> to <b>11/17/60</b> that (I) (we) lost saw the deceased alive on <b>11/16/60</b> and that death occurred at <b>11:15</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>David J. Gilmore</b>		22b. DATE SIGNED <b>11-17-1960</b>		22c. PHYSICIAN'S NAME (Type) <b>DAVID J Gilmore</b>	
22d. ADDRESS <b>Medical Center Salisbury, MD</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-18-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARSONS Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>SALISBURY, MARYLAND</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Hill Johnson</b>		ADDRESS <b>Salisbury, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 18 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Truena</b>		25c. REGISTRAR'S NAME <b>Arthur S. Truena</b>		25d. REGISTRAR'S ADDRESS <b>Salisbury, Md.</b>		25e. REGISTRAR'S PHONE <b>3-1111</b>	

Norman F. Baker

1811

WILSON

General Hospital  
Surgeon

Female White

Booth

November 17 1860

George Washington  
George Washington

10/21/18  
11/17/18

11/18/18  
11/18/18



## CERTIFICATE OF DEATH

Item 7 11-28-60 et

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>05X-</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>Rt 2964</u>	
3. NAME OF DECEASED (Type or print) <u>BEATRICE</u>		4. DATE OF DEATH <u>November 20 1960</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wesley Boner</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE GREEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Miss Nancy Hetherington, North Hill, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1-2-21-60</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>11-20-1960</u> to <u>11-21-1960</u> that (1) (we) last saw the deceased alive on <u>11-21-1960</u> , and that death occurred at <u>6A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William R. Ellis, Jr.</u> M.D.		22b. DATE SIGNED <u>11-21-60</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Nov 23, 1960</u>		23b. NAME OF CEMETERY OR CREMATORY <u>Ridgely</u>	
23c. DATE THEREOF		23d. LOCATION (City, town, or county) (State) <u>Ridgely, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George Moore Son, Denton, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 22 1960</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13143

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NANNIE</b> Middle <b>ELLEN</b> Last <b>BRADLEY</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>7th</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 30, 1882</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min.	11. IF UNDER 24 HRS. Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>R.D.# Delmar, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Wilson Wright</b>		14. MOTHER'S MAIDEN NAME <b>Annie Holloway</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>514 Willey St. - - Seaford, Delaware</b>	
17. INFORMANT <b>Mrs. Sara Collins (Daughter)</b>		Address <b>514 Willey St. - - Seaford, Delaware</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> 19 p. m. <b>N/A</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>11/7/60</b> , that (I) (we) last saw the deceased alive on <b>11/7/60</b> , and that death occurred at <b>6:00 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Andrew C. Mitchell</b>		22b. DATE SIGNED <b>Nov. 1/1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Andrew C. Mitchell</b>		22d. ADDRESS <b>Maryland Ave. Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Nov. 10, 1960</b>		23b. DATE THEREOF <b>Nov. 10, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Firemens Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Sharptown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>NOV 9 '60</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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13169

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13144

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>5 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Penn BRADLEY</u>				4. DATE OF DEATH Month Year <u>NOVEMBER 24 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 9, 1874</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Bradley</u>				14. MOTHER'S MAIDEN NAME <u>W. Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-01-7994</u>		17. INFORMANT Address <u>Mrs. W. Penn Bradley Mandela, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> <u>422.2</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 19</u> 19 <u>60</u> to <u>11:24</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>11-24</u> 19 <u>60</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>W. S. Ellis, Jr.</u>				22b. DATE SIGNED <u>11-24-60</u>		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-26-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mandela Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Mandela, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Smith Funeral Home</u>				25a. RECORD BY REGISTRAR <u>NOV 28 60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	
ADDRESS <u>Sharptown, Md.</u>				DATE			

1814

MAINTAIN A RECORD OF HEALTH

CERTIFICATE OF DEATH

1814





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
13170 13145											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				d. STREET ADDRESS <u>Johnson Road</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>D.O.A. at Pen Gen Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>ELIZABETH</u> Last <u>CHANDLER</u>					4. DATE OF DEATH Month <u>NOV.</u> Day <u>22</u> Year <u>19 60</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 24, 1920</u>		9. AGE (In years last birthday) <u>40</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Wilmington, Delaware</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>				
13. FATHER'S NAME <u>Thomas P. Steele</u>					14. MOTHER'S MAIDEN NAME <u>Annie V. Malin</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>Mr. Dixie Chandler (Husband)</u> <u>Salisbury, Maryland</u>						
17. INFORMANT <u>Mr. Dixie Chandler (Husband)</u> <u>Salisbury, Maryland</u>					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Methyl Alcohol poisoning</u> <u>880.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Chronic alcoholism</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ingested methyl alcohol</u>						
20c. TIME OF INJURY Month, Day, Year <u>10 L15</u> <u>Nov. 22, 1960</u> Hour <u>2:25</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Dr. Earl L. Royer</u> EXAMINER'S NAME (Type) <u>407 Camden Ave. Salisbury Md.</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Nov. 28 / 1960</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>Nov. 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or country) (State) <u>Salisbury, Maryland</u>				
23. FUNERAL DIRECTOR <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>					24a. REC'D BY REGISTRAR DATE <u>DEC 1 '60</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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M  
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M  
13146  
See: Birth Cert. et

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>19X-2</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Princess Anne General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u> d. STREET ADDRESS <u>Box 254</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Collins</u>		4. DATE OF DEATH Month Day Year <u>November 3 - 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 3, 1960</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. Months Days Hours Min. <u>5</u>
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Earl Sylvester Collins</u>		14. MOTHER'S MAIDEN NAME <u>Bernice Lottie Ballard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - 600 gm effort</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/3</u> 19 <u>60</u> to <u>11/3</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11/3</u> 19 <u>60</u> , and that death occurred at <u>7:40</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William C. Morgan</u> 22c. PHYSICIAN'S NAME (Type)		22b. ADDRESS M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/4/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST James</u>		23d. LOCATION (City, town, or county) (State) <u>Westover, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr. Princess Anne, Md</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 9 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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1810

CENTRAL DE DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

See: Birth Cert. et

13147

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Westover</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Collins</u>		4. DATE OF DEATH Month Day Year <u>November 3 - 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1960</u>
9. AGE (In years lost birthday) <u>9</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Earl Sylvester Collins</u>		14. MOTHER'S MAIDEN NAME <u>Bernice Lottie Ballard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>11-4-60</u>	
17. INFORMANT <u>William H. James Jr.</u>		Address <u>Princess Anne, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birth wt 580 gms)</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>apix 9 hrs</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>apix 9 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>11/3 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/3 1960</u> to <u>11/3 1960</u> that (I) (we) last saw the deceased alive on <u>11/3 1960</u> and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred C. Kells</u>		22b. DATE SIGNED <u>11/3/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Medical Center - Salisbury, Md</u>		22d. ADDRESS <u>Salisbury, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/4/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST James</u>		23d. LOCATION (City, town, or county) (State) <u>Westover, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr.</u>		ADDRESS <u>Princess Anne, Md</u>	
25a. REG. BY REGISTRAR <u>NOV 5 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>	

2282172XV0

THE NEW YORK STATE DEPARTMENT OF HEALTH  
DIVISION OF HEALTH SERVICES  
ALBANY, NEW YORK 12242



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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13173  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13148

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN lb <b>7 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pine Bluff State Hospital</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Centerville</b> d. STREET ADDRESS <b>17X-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES ALISON DADDS</b>			4. DATE OF DEATH Month Day Year <b>Nov. 30 19 60</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1888</b>		9. AGE (In years lost birthday) yrs. <b>72</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Huckster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William J. Dadds</b>			14. MOTHER'S MAIDEN NAME <b>Elybeth Jizzie Allen</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-16-72284</b>		
17. INFORMANT <b>Records of Pine Bluff Hospital</b>			Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiovascular disease</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 23</b> 19 <b>60</b> , to <b>Nov. 30</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Nov. 30</b> 19 <b>60</b> , and that death occurred at <b>8:45</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Edward P. Ritchings</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 30, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward P. Ritchings, M.D.</b>				22d. ADDRESS <b>Pine Bluff State Hosp., Salisbury, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 3-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chestnutfield</b>		23d. LOCATION (City, town, or county) (State) <b>Centerville Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Butcher, Jr.</b>				ADDRESS <b>Centerville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 6 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

13114

LETTER OF 2. 11. 1943

13114

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13114

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

13217

STATE OF MARYLAND  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13149

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>506 Chestnut St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>HOOKS</b> Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>6th</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1892</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>10</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night Watchman-Factory-Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R.D.# Pittsville, Md</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Davis</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Campbell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>Unk</b>	
17. INFORMANT <b>Mrs. Bertha Ellen Davis (Wife)</b>		Address <b>506 Chestnut St. Delmar, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Coronary arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1958 to 1959</b> , that (I) (we) last saw the deceased alive on <b>December 5, 1959</b> , and that death occurred at <b>2:00 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L.V. Sohler</b>		22b. DATE SIGNED <b>Nov. 7 / 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. L.V. Sohler</b>		22d. ADDRESS <b>Delmar, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 8, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Farlow Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>R.D.# Pittsville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>NOV 9 '60</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

1818

THE DAY OF DEATH

1818



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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13174  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13150

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>DEER'S HEAD STATE HOSPITAL</b>				d. STREET ADDRESS <b>--</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Priscilla</b> Last <b>Devereaux</b>				4. DATE OF DEATH Month <b>11</b> Day <b>8</b> Year <b>1960</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-5-81</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>		IF UNDER 24 HRS. Hours <b>79</b> Min. <b>79</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
11. BIRTHPLACE (State or foreign country) <b>Snow Hill, Md</b>				12. CITIZEN OF WHAT COUNTRY? <b>md</b>			
13. FATHER'S NAME <b>Joseph J. Devereaux</b>				14. MOTHER'S MAIDEN NAME <b>Henretta Evans</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Joseph J. Devereaux</b>				Address <b>Snow Hill, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>434.1</b> IMMEDIATE CAUSE (a) <b>Congestive heart disease</b> DUE TO (b) <b>10 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>10 days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus; arteriosclerosis, general.</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-19</b> to <b>11-8, 1960</b> , that (I) (we) last saw the deceased alive on <b>11-8</b> 1960, and that death occurred at <b>10:45 p.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>L. V. Maldve, M.D.</b>				22b. DATE SIGNED <b>11-9-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M.D.</b>				22d. ADDRESS <b>Deer's Head State Hospital Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Nov 13/60</b>				23b. DATE THEREOF <b>Nov 13/60</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Whitcomb Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Snow Hill Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elmer E. Dinnis</b>				25a. REC'D BY REGISTRAR <b>NOV 14 '60</b>			
ADDRESS <b>Snow Hill, Md</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

13174

STATE OF NEW YORK

13174

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "State of New York" and "County of" are faintly visible.]*



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13151

13175

Item 2 Film 6276 12-2-60 et

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>1 1/2 Yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>John B. Parsons Home</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>307 Newton St.</b> <b>John B. Parsons Home</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>SINA TAYLOR DICKERSON</b>			4. DATE OF DEATH Month <b>11</b> Day <b>25</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1863</b>		9. AGE (In years last birthday) yrs. <b>97</b> IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Thomas Taylor</b>			14. MOTHER'S MAIDEN NAME <b>Sarah White</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>John B. Parsons Home, Same</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>442X</b> IMMEDIATE CAUSE (a) <b>Cardiovascular renal disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-7</b> to <b>11-25</b> , 19 <b>60</b> , that (I) (we) lost the deceased alive on <b>11-29</b> , 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Philip A. Insley</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-26-1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley</b>		22d. ADDRESS <b>Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-27-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 29 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Farns</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13176

13152

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>15 Mons.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Rr. Sanatorium</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EMMA</b> First <b>FLORENCE</b> Middle <b>DISHAROON</b> Last				4. DATE OF DEATH Month <b>11</b> Day <b>14</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1860</b>		9. AGE (In years last birthday) yrs. <b>100</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Josuha Turner</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. T.B. Mumford- Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac failure</b> 420.0 DUE TO <b>Senile Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>11/14/60</b> 19 that (I) (we) last saw the deceased alive on <b>11/11</b> 19 <b>60</b> and that death occurred at <b>11/14/60</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>A.C. Mitchell</b>				22b. ADDRESS <b>Maryland Ave., Salisbury, Maryland</b>		22c. DATE SIGNED <b>11/16/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. A.C. Mitchell</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-17-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shad Point Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Shad Point, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				25a. REC'D BY REGISTRAR <b>NOV 18 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

*Journal of Management Studies*, 1997, 34(6), 681-690

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Figure 10.10

## CERTIFICATE OF DEATH

Reg. Dist. No.

13153

13218.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Metow Brook Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pierce</u> Middle <u>A.</u> Last <u>Doane</u>		4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 13, 1959</u>
9. AGE (In years last birthday) <u>13</u>		10. IF UNDER 1 YEAR Months <u>13</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Doane</u>		14. MOTHER'S MAIDEN NAME <u>Carolyn Horsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>501X</u> DUE TO <u>Acute Broncho Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Viral Bronchitis</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 19, 1960</u> to <u>Nov. 20, 1960</u> that I last saw the deceased alive on <u>Nov. 19, 1960</u> and that death occurred at <u>7:00</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Herbert Sembley</u> M.D.		ADDRESS (Street, city or town, state) <u>400 E Church St Salisbury Md</u>	
PHYSICIAN'S NAME (Type) <u>G. Herbert Sembley</u>		DATE SIGNED <u>11/20/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>11/23/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>green acres</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton St. Stewart</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Thoms</u>	
ADDRESS <u>Salisbury Md</u>		DATE <u>NOV 29 '60</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.

CERTIFICATE OF DEATH

1918

DECEASED  
NAME  
AGE  
SEX  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
SIGNATURE OF DECEASED  
SIGNATURE OF WITNESSES  
SIGNATURE OF CLERK  
SIGNATURE OF MINISTER OF THE GOSPEL





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13220 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
13154									
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Rural) Fruitland</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>(Railroad Crossing) Md. Route #13 South of Fruitland</b>					d. STREET ADDRESS <b>R.D.# 1 (Meadow Bridge Rd)</b>				
3. NAME OF DECEASED (Type or print) <b>FAYE</b>					4. DATE OF DEATH Month <b>NOV.</b> Day <b>10</b> Year <b>19 60</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 25, 1938</b>		9. AGE (in years last birthday) <b>22</b> yrs. IF UNDER 1 YEAR: Months <b>9</b> Days <b>15</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee-Shirt Factory-Operator</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>"Operator"</b>			11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>No Record</b>					14. MOTHER'S MAIDEN NAME <b>Gladys Wilkerson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <b></b>				
17. INFORMANT <b>Mr. Elwood West (Grandfather)</b>					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compound Fracture of Skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden</b> DUE TO (c) <b></b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger Auto - Struck by Train</b>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11/ 10, 60</b> p.m. <b></b>			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Railroad Crossing - Fruitland (Wico.) Md.</b>		20f. (City or town) (County) (State) <b></b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b> EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md.</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Nov. 14 / 1960</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 13, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Shad Point Cemetery-</b>		22d. LOCATION (City, town, or country) (State) <b>R.D. Salisbury, Maryland</b>			
23. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>					24a. REC'D BY REGISTRAR <b>NOV 16 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>				

WESTLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1930

WESTLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1930

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is mostly blank with some faint markings and two punch holes on the right side.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13155

13177

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>23X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>DORSEY</u> Last <u>DORSEY</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 17, 1960</u>	
9. AGE (In years lost birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>47</u> Days <u>5</u> Hours <u>47</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, MD</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James' Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Dorsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or exempt) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Yvonne Weocott, Nassawadox, Va</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral edema</u> (c) <u>Fetal anoxia</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atelectasis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Salisbury, MD</u>				20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> 19 <u>60</u> to <u>11/18</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11/18</u> 19 <u>60</u> , and that death occurred at <u>2:40</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>William C. Morgan</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11/19/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>William C. Morgan</u>				22d. ADDRESS <u>Medical Center Salisbury, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 21/60</u>		<u>Ballins Temple Land</u>		<u>Snow Hill, MD Rural #1</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maye E. Dumas</u>				25a. REC'D BY REGISTRAR <u>Nov 23 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1817

*[Faint, illegible handwriting throughout the form, likely bleed-through from the reverse side.]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13178 Items 8 & 9. Film G-274 11/10/60.cac.

Reg. Dist. No.

13156

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>12</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>413 Wailes St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Pierre</b> First <b>Fleischauer</b> Middle <b>Jr.</b> Last		4. DATE OF DEATH <b>11-5-60</b> Month <b>11</b> Day <b>5</b> Year <b>60</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1925</b> <b>Nov. 23, 1925</b>
9. AGE (In years last birthday) <b>35</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>5</b> IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Pierre Fleischauer Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Florence Powell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>World War # 2</b>		16. SOCIAL SECURITY NO. <b>World War # 2</b>	
17. INFORMANT <b>Mrs. Thelma Hickman Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compound fracture of skull-occipital-</b> DUE TO <b>Fractured cervical spine</b> Conditions, if any, which gave rise to immediate cause (b) <b>Crushed left chest.</b> DUE TO <b></b> (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Driving car that ran out of control, hit pole and threw him out.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>threw him out.</b>	
20c. TIME OF INJURY Month, Day, Year <b>2:35 A.M. 11-5-60</b> Hour <b>2:35</b> g. m. <b>A.M.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Highway</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Salisbury Wicomico Md.</b>		20f. (City or town) <b>Salisbury</b> (County) <b>Wicomico</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Earl L. Royer</b> EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		DATE SIGNED <b>11-8-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/6/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dale</b>		22d. LOCATION (City, town, or county) <b>Whaleyville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley</b> ADDRESS <b>Salisbury, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV/8 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			







13179  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

13157

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>7 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POCOMOKE CITY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>203 SIXTH STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM M. Fleming</u>				4. DATE OF DEATH Month Day Year <u>November 14 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 3, 1875</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LUMBER MFG.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WILLIAM E. FLEMING</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH SPROUL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>170-10-6339</u>		17. INFORMANT Address <u>MRS MARY M. FLEMING, 203 SIXTH STREET, POCOMOKE CITY, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> DUE TO (b) <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-9</u> 19 <u>60</u> to <u>11-14</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11-14</u> 19 <u>60</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Wilbur R. Ellis</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-15-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILBUR R. ELLIS</u>				22d. ADDRESS <u>SALISBURY, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-17-60</u>		23c. NAME OF CEMETERY <u>ST. MARY EPISCOPAL</u>		23d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Watson</u> ADDRESS <u>POCOMOKE CITY, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 21 60</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

13180

13159

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>24 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula Gen. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Glady's T. Gattis</u>		4. DATE OF DEATH <u>November 24 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/1902</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>15</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Wainwright</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-3527</u>	
17. INFORMANT <u>Louise Wainwright</u>		Address <u>Tyaskin MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X Broncho - PNEUMONIA</u> DUE TO (b) <u>PULMONARY METASTATIC CARCINOMA</u> DUE TO (c) <u>ADENOCARCINOMA BREAST</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>17 NOV. 1960</u> to <u>24 NOV. 1960</u> that (I) (we) last saw the deceased alive on <u>24 NOV. 1960</u> and that death occurred at <u>11:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Saunders</u>		22b. DATE SIGNED <u>11/25/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. SAUNDERS</u>		22d. ADDRESS <u>NANTICOKE MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/27/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Tyaskin Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Tyaskin, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Messing</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '60</u>	
ADDRESS <u>Birch Ave, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kress</u>	

13180

13180

CERTIFICATE OF DEATH



*[Faint, mostly illegible text, likely a form for a death certificate. The text is mirrored across the page, suggesting bleed-through from the reverse side.]*





13181

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13160

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wic.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>18 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ceriusula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rufus</u> First Middle Last				4. DATE OF DEATH <u>November 5 1960</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 14 1888</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.		IF UNDER 24 HRS. <u>—</u> Hours <u>—</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>VA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>ex SA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>214-36-5287</u>		17. INFORMANT <u>Archie Sorhom</u> Address <u>Palmer</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia</u> <u>422.1</u> DUE TO <u>Thrombosis middle cerebral artery aft.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Anterior resective C. V. D.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>15 days</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/25/60</u> 19 <u>60</u> to <u>11/5/60</u> 19 <u>60</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>11/5/60</u> 19 <u>60</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph C. Fitzgerald M.D.</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11-8-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M West</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>NOV 9 60</u> DATE	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
TSM 9/59

13182

13161

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
c. LENGTH OF STAY IN 1b <u>5 DAYS</u>		d. STREET ADDRESS <u>11 CENTRAL AVENUE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MAURICE</u> Middle <u>WILLIAM</u> Last <u>Gray</u>		4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 21, 1902</u>
9. AGE (In years lost birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONDUCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>EDWARD GRAY</u>	
14. MOTHER'S MAIDEN NAME <u>JENNIE MASON</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>  </u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>MRS ADA B. GRAY, 11 CENTRAL AVENUE, Pocomoke City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> DUE TO <u>420-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema &amp; fibrosis; Mesenteric Thrombosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>11-1</u> , 19 <u>60</u> , to <u>11-7</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11-7</u> , 19 <u>60</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>David J. Gilmore</u>		22b. DATE SIGNED <u>11/7/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE</u>		22d. ADDRESS <u>SALISBURY, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-8-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SALEM METHODIST</u>		23d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry L. Watson</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>  </u>	
ADDRESS <u>Pocomoke City, Md.</u>		DATE <u>NOV 9 '60</u>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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13183

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13162

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>610 S.Division St</b>		d. STREET ADDRESS <b>610 S.Division St</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARLAND</b> Middle <b>B</b> Last <b>HOLLOWAY</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>29th</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Single</b>	8. DATE OF BIRTH <b>June 2, 1903</b>
9. AGE (In years lost birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>57</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Operator of Own Garage</b>	
11. BIRTHPLACE (State or foreign country) <b>Delmar, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Caldwell F. Holloway</b>		14. MOTHER'S MAIDEN NAME <b>Ada A. Hastings</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>151X</b>	
17. INFORMANT <b>Mrs. Ada A. Holloway (Mother)</b>		Address <b>610 S. Div. St Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>gastrointestinal hemorrhage</b> DUE TO <b>Carcinoma of Stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3 yrs.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 2, 1959</b> to <b>Nov. 29, 1960</b> that (I) (we) last saw the deceased alive on <b>Nov 28, 1960</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>Nov. 29 / 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert T. Adkins</b>		22d. ADDRESS <b>Fruitland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 1, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Forest Grove Cemetery-R.D.#</b>		23d. LOCATION (City, town, or county) (State) <b>Parsonsborg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
25a. REC'D BY REGISTRAR <b>DEC 1 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

STATE OF TEXAS,  
COUNTY OF \_\_\_\_\_

\_\_\_\_\_,  
Notary Public in and for the State of Texas,  
do hereby certify that \_\_\_\_\_  
is the true and correct copy of the \_\_\_\_\_  
of \_\_\_\_\_  
as the same appears from the records of said County.

\_\_\_\_\_  
Notary Public

My Commission Expires \_\_\_\_\_

451



## 13222 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mardela</u>		<u>84 yrs</u>		TOWN <u>Mardela</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bridge St. &amp; Athol Rd.</u>				STREET ADDRESS (If rural give location) <u>Bridge St. &amp; Athol Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Cora</u> (Middle) <u>Elizabeth</u> (Last) <u>Hopkins</u>				(Month) <u>Nov</u> (Day) <u>14</u> (Year) <u>19 60</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>WIDOW</u>	8. DATE OF BIRTH <u>Oct 2, 1876</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>postmistress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Noah Bennett</u>				14. MOTHER'S MAIDEN NAME <u>Mary Bradley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Mrs. Florence Bennett, Mardela, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
42a) IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>7 day</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 7, 1960</u> , to <u>Nov 14, 1960</u> , that I last saw the deceased alive on <u>Nov 14, 1960</u> , and that death occurred at <u>11/15/60</u> M, from the causes and on the date stated above.							
SIGNATURE <u>H. S. Kuhlman</u>		M. D.		ADDRESS (Street, city, town, state) <u>Sharpton Md.</u>		DATE SIGNED <u>11/15/60</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 17-60</u>		NAME OF CEMETERY OR CREMATORY <u>Mardela</u>		LOCATION (City, town, or county) <u>Mardela, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Kuhlman</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>NOV 18 '60</u>				<u>Smith Funeral Home Sharpton, Md.</u>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

1925

200 000 400

1. PLACE OF DEATH

MARYLAND

COUNTY

CITY

STREET

APARTMENT

ROOM

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

NAME OF BURIAL

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF RETURN

DATE OF DEATH

DATE OF BURIAL

DATE OF RETURN

DATE OF DEATH

DATE OF BURIAL

DATE OF RETURN

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DATE OF DEATH

DATE OF BURIAL

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DATE OF BURIAL

DATE OF RETURN

DATE OF DEATH

DATE OF BURIAL

DATE OF RETURN

SMOOTHING

1. Name of deceased  
2. Date of death  
3. Place of death  
4. Cause of death  
5. Date of burial  
6. Place of burial  
7. Name of burial  
8. Age  
9. Sex  
10. Race  
11. Religion  
12. Education  
13. Occupation  
14. Date of birth  
15. Place of birth  
16. Date of entry  
17. Date of departure  
18. Date of return  
19. Date of death  
20. Date of burial  
21. Date of return  
22. Date of death  
23. Date of burial  
24. Date of return  
25. Date of death  
26. Date of burial  
27. Date of return  
28. Date of death  
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91. Date of death  
92. Date of burial  
93. Date of return  
94. Date of death  
95. Date of burial  
96. Date of return  
97. Date of death  
98. Date of burial  
99. Date of return  
100. Date of death

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13184

CERTIFICATE OF DEATH

13164

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>301 Pond St</b>				d. STREET ADDRESS <b>301 Pond St</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>NETTIE</b> Middle <b>MARY</b> Last <b>HURLEY</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 20, 1883</b>		9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>29</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Seaford, Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James A. Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Lingo</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Mr. Benjamin F. Hurley (Husband)</b> Address <b>301 Pond St Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>450.0</b> IMMEDIATE CAUSE (a) <b>Generalized Atherosclerosis.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) <b></b> (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>11/8/60</b> 19 to <b>11/19/60</b> 19, that (I) (we) last saw the deceased alive on <b>11/16/60</b> 19, and that death occurred at <b>8:10 A.M.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Andrew C. Mitchell</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 21 / 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Andrew C. Mitchell</b>				22d. ADDRESS <b>Maryland Ave. Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 22, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem. Park.</b>		23d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b> (State) <b></b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>				25a. REC'D BY REGISTRAR <b>NOV 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

13185

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13165

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Seminole &amp; Shawnee</b>		d. STREET ADDRESS <b>Seminole &amp; Shawnee</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Jackson</b> Last <b>Jackson</b>		4. DATE OF DEATH Month <b>November</b> , Day <b>26</b> , Year <b>1960</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>C.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 4, 1863</b>
9. AGE (In years last birthday) <b>97</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>26</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Months <b>9</b> Days <b>26</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Columbus Crowford</b>		14. MOTHER'S MAIDEN NAME <b>Micie Burris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Serraine Holloway</b> Address <b>Seminole St Salisbury Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>cardiac failure</b> (c) <b>152.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>chronic pneumonia Right lower lobe</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/2</b> , 19 <b>51</b> , to <b>death</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>11/2</b> , 19 <b>60</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1241/60</b> DATE SIGNED <b>12/1/60</b>			
ACTUAL SIGNATURE <b>E. M. Larmo</b> M.D.			
PHYSICIAN'S NAME (Type) <b>E. M. LARMO RE</b>		<b>100 Grove St, Delmar, Del</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial 11/30/ 1960</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>union</b>		22d. LOCATION (City, town, or county) (State) <b>Delmar Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clinton B. Stewart</b> ADDRESS <b>Salisbury Md</b>		24a. REC'D BY REGISTRAR <b>DATE DEC 5 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

13185

NO. 100-100000

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *10/15/1918*

5. Place of death: *Home*

6. Cause of death: *Heart failure*

7. Signature of physician: *Dr. J. H. Smith*

8. Signature of registrar: *John Doe*

9. Date of registration: *10/20/1918*

10. Place of registration: *City of New York*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
TSM 9/59

1  
13186  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13166

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>307 Ohio Ave</b>				d. STREET ADDRESS <b>307 Ohio Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES LEE JOHNSON</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 3rd 19 60</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 1, 1874</b>			
9. AGE (In years lost birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>2</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Furniture Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Salesman</b>		11. BIRTHPLACE (State or foreign country) <b>Worcester Co., Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>									
13. FATHER'S NAME <b>James Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Shockley</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b></b>					
17. INFORMANT Address <b>Mrs. Harriet Balderson (Daughter) 307 Ohio Ave., Salisbury, Maryland</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>C. V. A.</b> DUE TO <b>Thrombosis</b> (c) <b></b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>N/A 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>			
20f. (City or town) <b>N/A</b> (County) <b></b> (State) <b></b>									
21. I certify that (I) (this hospital) attended the deceased from <b>11/2 1960</b> , to <b>11/3 1960</b> , that (I) (we) last saw the deceased alive on <b>11/3 1960</b> , and that death occurred at <b>4:30</b> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <b>W. B. Smith</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 4/1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. William B. Smith</b>				22d. ADDRESS <b>Salisbury, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Nov. 5, 1960</b>				23b. DATE THEREOF <b>Nov. 5, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Whatcoat Cemetery</b>			
23d. LOCATION (City, town, or county) <b>Snow Hill, Maryland</b>				(State) <b></b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		25a. REC'D BY REGISTRAR <b>NOV 7 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>									

18186

CERTIFICATE OF DEATH

MADE IN U.S.A.  
JONES & CO. LTD.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13187 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13167

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>417 Patterson Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>LILLIE VIRGINIA KELLEY</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>March 1, 1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Worcester Co. Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Emory E. Griffin</u>				14. MOTHER'S MAIDEN NAME <u>Sallie K. (Sarah) Dykes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mr. William Kelley (Son)</u>				Address <u>R.D.# Hebron, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>904</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Rt. Hip</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <u>Fall of Home</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10:26</u> p.m. <u>1960</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dr. Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>407 Camden Ave. Salisbury, Md.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>Nov. 15</u> /1960							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 16, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wango Church Cemetery - R.D.# Parsonsburg, Md.</u>		22d. LOCATION (City, town, or country) (State) <u>Parsonsburg, Md.</u>	
23. FUNERAL DIRECTOR <u>HOLLOWAY &amp; COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>			
24a. REC'D BY REGISTRAR <u>NOV 16 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Wm. S. Frawley</u>			

13188

13188 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13188

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>13188</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>13168</div> </div> </div> <div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>13188</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>13168</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>						c. LENGTH OF STAY IN 1b <b>1 Day</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Aboard- Freighter-Consul Horn</b>						d. STREET ADDRESS <b>Wilhelmshafen, Germany</b>					
3. NAME OF DECEASED (Type or print) <b>Calo Alvin KUFFNER</b>						4. DATE OF DEATH Month <b>11</b> Day <b>28</b> Year <b>60</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-13-1900</b>		9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>28</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Shipping</b>				11. BIRTHPLACE (State or foreign country) <b>Hamburg, Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>Germany</b>	
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Unknown ***</b>						16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Consul Horn Freighter records (Passport), Caravel Shipping, 26 Broadway N.Y. 4 N.Y.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull with intra-cranial hemorrhage- Min.</b> 901.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell down ladder to engine room.</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11-28-60</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Aboard ship.</b>			
				20f. (City or town) <b>Salisbury</b>				20g. (County) <b>Wicomico Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE <b>Earl L. Royer</b>						DATE SIGNED <b>11-30-60</b>					
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				22b. DATE THEREOF <b>12-1-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>J.W.M. Lee's Crematory</b>				22d. LOCATION (City, town, or country) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>						24a. REC'D BY REGISTRAR <b>DEC 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

13188 HOSPITAL EXAMINER'S CERTIFICATE OF DEATH

Alcoholism

Alcoholism

Alcoholism - Chronic - Terminal

Alcoholism

Alcoholism

0-10-0

22

Alcoholism

Alcoholism

Alcoholism



Alcoholism - Chronic - Terminal

Alcoholism

Alcoholism

Alcoholism - Chronic - Terminal

Alcoholism - Chronic - Terminal

Alcoholism - Chronic - Terminal

Alcoholism

Alcoholism - Chronic - Terminal

Alcoholism - Chronic - Terminal

Alcoholism - Chronic - Terminal



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
ISM 9/59

13189

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13169

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monie</u> d. STREET ADDRESS <u>19x-2</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>LAWSON</u> Last <u>LAWSON</u>		4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/5/1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George S. Lawson</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Sterling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Jack Bryan</u> Address <u>Allen Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> DUE TO (b) <u>4-22-2</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>cardiac</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cardiac</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-1</u> 19 <u>60</u> to <u>11-12</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11-12</u> 19 <u>60</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>11-12-60</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/15/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oridio</u>		23d. LOCATION (City, town, or county) (State) <u>Oridio Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James Hunter Purcell</u> ADDRESS		25a. REC'D BY REGISTRAR <u>NOV 28 '60</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>			

Mr  
Morris

Elizabeth

F W

George J. Lowman

Mr Jack Bryan Allen

George J. Lowman

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13190

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13170

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>23X-2</u>			
3. NAME OF DECEASED (Type or print) First <u>KATIE</u> Middle <u>E.</u> Last <u>LECATES</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 18, 1885</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN, MD RFD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Ebenezer Wainwright</u>				14. MOTHER'S MAIDEN NAME <u>HESTER JARVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>219-14-4974</u>		17. INFORMANT Address <u>MRS. SOATH SHOCKLEY BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Encephalitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 16</u> 19 <u>60</u> to <u>Nov. 21</u> 19 <u>60</u> that (I) ( <u>we</u> ) last saw the deceased alive on <u>Nov. 21</u> 19 <u>60</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>David J. Eickore</u>				22b. DATE SIGNED <u>11/21/60</u>		22c. PHYSICIAN'S NAME (Type) <u>David J. Eickore</u>	
22d. ADDRESS <u>MD.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>11/24/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS</u>	
23d. LOCATION (City, town, or county) (State) <u>BISHOPVILLE MD</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burby</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 28 60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

18190

CENTRAL AIR OF DEATH

18190

✓

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "CENTRAL AIR OF DEATH" are visible.]*

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13191 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
13171									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>E. W. Pen. Gen. Hospital</u>					d. STREET ADDRESS <u>(Marine Camp)</u>				
3. NAME OF DECEASED (Type or print) <u>PAUL HARRISON LORD</u>					4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>19</u> Year <u>1960</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 14, 1940</u>		9. AGE (In years last birthday) <u>20</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Marines -Transportation-</u>					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Falls River, Mass</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>									
13. FATHER'S NAME <u>Elmer F. Lord</u>					14. MOTHER'S MAIDEN NAME <u>Dorothy M. Murray</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>X YES 1960</u>					16. SOCIAL SECURITY NO. <u>  </u>				
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture dislocation of cervical spine</u> DUE TO (b) <u>8-2-3X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>  </u> DUE TO (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>Driving car that ran off road.</u>				
20c. TIME OF INJURY Month, Day, Year <u>12:10 A.M. / 19 1960</u> Hour a.m. <u>  </u> p.m. <u>  </u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>S. Div. St. Ext. Rural-Salisbury (Wico.) Md.</u>					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Dr. Earl L. Royer</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>407 Camden Ave. Salisbury, Md.</u>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
DATE SIGNED <u>Nov. 21 / 1960</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>Nov. 22, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>			22d. LOCATION (City, town, or country) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR <u>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</u>					ADDRESS				
24a. REC'D BY REGISTRAR <u>NOV 22 '60</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>				





## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13223

## CERTIFICATE OF DEATH

13172

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY <u>Sharptown</u>		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN <u>Sharptown</u>		STREET ADDRESS (If rural give location)	
TOWN <u>rural Mardela</u>		<u>4 days</u>		ADDRESS <u>1 Main &amp; Mardela Road</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Maple Shade Nursing Home</u>							
<b>3. NAME OF DECEASED</b> (Type or Print) <u>HAZEL Phillips</u> (First) <u>LOWE</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>Nov.</u> (Day) <u>24</u> (Year) <u>1960</u>			
<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>married</u>		<b>8. DATE OF BIRTH</b> <u>Aug 14, 1902</u>	
<b>9. AGE last birthday</b> <u>58</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Textile Operator</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b>		<b>13. FATHER'S NAME</b> <u>Holland Smith</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Virgie Phillips</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>216-03-5065</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Levin Lowe, Sharptown, Md.</u>			
<b>18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>I</b> IMMEDIATE CAUSE (A) <u>To carcinoma Breast</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u>			
ANTECEDENT CAUSE(S) (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Nov 24</u> , 19 <u>58</u> , to <u>Nov 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>60</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>H. S. Kuhlman</u> M. D.				<b>ADDRESS</b> (Street, city, town, state) <u>Sharptown Md</u> <b>DATE SIGNED</b> <u>11/26/60</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>11-27-60</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Firemens</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Sharptown, Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>NOV 28 '60</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Smith Funeral Home</u>		<b>ADDRESS</b> <u>Sharptown, Md.</u>	
<b>DATE</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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13192  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
13173

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>3057 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head Hospital</b>		d. STREET ADDRESS <b>P.O. Box #12.</b>	
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Eleanor</b> Last <b>McCurdy</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 23, 1872.</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unk</b>	
11. BIRTHPLACE (State or foreign country) <b>Lawrence, Kansas.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jesse Mc Curdy</b>		14. MOTHER'S MAIDEN NAME <b>Emily Anderson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Records Of Deers Head State Hospt. Salisbury, Maryland.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic congestion of the lungs</b> 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Arteriosclerosis, generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs.</b> <b>Years</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinsonism</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 23, 1952</b> to <b>Nov. 28, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov. 28, 1960</b> , and that death occurred at <b>12:45 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. V. Maldve, M. D.</b>		22b. DATE SIGNED <b>11/28/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>Nov. 30, 1960.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>J. Wm. Lees Sons</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Holloway &amp; Company, Salisbury, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 1 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
13193  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14532

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>120 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fishing Creek, Maryland.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>None</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Nannie</b> Middle <b>Raye</b> Last <b>McGlaughlin</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>29</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/20/1879</b>
9. AGE (In years last birthday) <b>81</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>J. TOLLEY</b>		14. MOTHER'S MAIDEN NAME <b>MARY CASKEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>DEER'S HEAD STATE HOSP.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>491X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1</b> 19 <b>60</b> , to <b>Nov. 29</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Nov. 29</b> 19 <b>60</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. V. Maldve</b>		22b. DATE <b>11/29/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/2/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service, Cambridge, Maryland.</b>		25a. REC'D BY REGISTRAR <b>DEC 9 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>			

2/20/1977 B281

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DEER'S HEAD STATE HOSP  
MARY GASK KEY

NO TOLLED



13194

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13174

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>830 Brown St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dallas</u> <u>Henry</u> <u>Moore</u>				4. DATE OF DEATH Month Day Year <u>November</u> <u>11</u> <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 26, 1890</u>		9. AGE (In years last birthday) yrs. <u>70</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager-Sand &amp; Gravel Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Houston, Delaware</u>		11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Levin Henry Moore</u>				14. MOTHER'S MAIDEN NAME <u>Tempa Gordy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mrs. Mattie J. Moore (Wife)</u> Address <u>830 Brown St Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE COR PULMONALE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASPIRATION PNEUMONIA + PULMONARY EMPHYSEMA</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ch R. Cholecystitis + Cholelithiasis - Cholecystectomy</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>N/A</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) (County) (State) <u>N/A</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 4, 1960</u> to <u>Nov 11, 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov 11, 1960</u> , and that death occurred at <u>12 N</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William B. Long</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov 11, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. William B. Long</u>				22d. ADDRESS <u>Medical Center Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 14, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 16 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

18184

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*[Faint, illegible text and markings on a form, likely a Certificate of Death. The text is mirrored and difficult to read.]*

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1319 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13175

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		d. STREET ADDRESS <b>715 Moore St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Isadore</b>		First		Middle		Last <b>Morris</b>		4. DATE OF DEATH <b>11-28-60</b>		Month		Day		Year	
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 15, 1960</b>		9. AGE (In years last birthday) <b>60/39</b> yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Wicomico Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Etta Morris</b>		14. MOTHER'S MAIDEN NAME <b>P?</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-05-8770</b>	
17. INFORMANT <b>Ruth Hargrave</b>		Address <b>Salisbury Md</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardio-vascular disease</b> DUE TO (c) <b>Years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) <b>Salisbury</b>		(County) <b>Wicomico</b>		(State) <b>Md</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-3-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brown Acres Cem</b>		22d. LOCATION (City, town, or country) <b>Salisbury Md</b>		(State) <b>Md</b>		23. FUNERAL DIRECTOR <b>W.D. Samuel Home</b>		ADDRESS <b>Salisbury Md</b>		24a. REC'D BY REGISTRAR <b>DEC 6 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		24c. DATE <b>DEC 6 '60</b>		24d. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		24e. DATE <b>DEC 6 '60</b>		24f. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		24g. DATE <b>DEC 6 '60</b>		24h. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		24i. DATE <b>DEC 6 '60</b>	

VS. A15ME  
5M 7/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give page 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

13196

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13176

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>140 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eden, Maryland</b>		1978-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>Rt. 1, Box 11</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Nairne</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> , Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 14, 1923</b>
9. AGE (In years lost birthday) <b>37 yrs.</b>		10. IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min. <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ulysses Cottman</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Cannon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Deer's Head State Hospital Records, Salisbury</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/7/60</b> , 19 <b>60</b> , to <b>11/24</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Nov. 24th</b> 19 <b>60</b> , and that death occurred at <b>7: P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>V. Juerman</b>		22b. DATE <b>11/25/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>V. Juerman, M.D.</b>		22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/27/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St Mary</b>		23d. LOCATION (City, town, or county) (State) <b>West Post Office, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William H. James Jr. Princess Anne, Md</b>		25a. REC'D BY REGISTRAR <b>NOV 28 60</b>	
ADDRESS <b>William H. James Jr. Princess Anne, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

13197

13177

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>2205 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>OSX-2</b>			
3. NAME OF DECEASED (Type or print) First <b>Lulu</b> Middle <b>Newcomer</b> Last <b>Newcomer</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>16</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1869</b>		9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>William Neal</b>			
14. MOTHER'S MAIDEN NAME <b>unknown</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>—</b>				17. INFORMANT <b>M. Edward Newman</b> Address <b>Easton Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO (b) <b>Arteriosclerosis, general</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>—</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute cholecystitis</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>Yrs</b> <b>Yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Nov. 3</b>				20g. (County) <b>15</b>		20h. (State) <b>Nov. 16</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 3</b> 19 <b>60</b> , to <b>Nov. 16</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Nov. 15</b> 19 <b>60</b> , and that death occurred at <b>3A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>L. V. Maldve</b>				22b. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>		22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>	
23a. DATE THEREOF <b>Nov. 18, 1960</b>				23b. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cem</b>		23c. LOCATION (City, town, or county) <b>Easton Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newman &amp; Son</b>				25a. REC'D BY REGISTRAR <b>NOV 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1313

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

1313

TO : DIRECTOR, FBI (100-374301)  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page. It appears to be a memorandum or report detailing an investigation.]

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13198

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

13178

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Age Home</u>		d. STREET ADDRESS <u>23X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Parson</u> Last <u>Parson</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19, 1893</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>YARD-Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Parson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Cropper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Alice Soane</u> Address <u>Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X</u> DUE TO <u>Central Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO <u>Unk</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Keyphosis - Scoliosis - Spine</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 12, 1960</u> to <u>Nov. 19, 1960</u> that (I) (we) lost the deceased alive on <u>Nov. 16, 1960</u> and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>G. Herbert Sembley</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov. 21/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Herbert Sembley</u>		22d. ADDRESS <u>Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 27, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hall's Hill Cem.</u>		23d. LOCATION (City, town, or county) <u>Pocomoke City, Md.</u> (State) <u></u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Whorton - New Church, Va.</u> ADDRESS <u></u>		25a. REC'D BY REGISTRAR <u>NOV 23 '60</u> DATE <u></u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

1918

Wisconsin

Salisbury

Mr. Thomas

George

Mr. [unclear]

For Person

No

1918

STATE OF WISCONSIN

COUNTY OF [unclear]

Madison

For [unclear]

Person

Oct 1918

Madison

Elizabeth [unclear]

[unclear]

[unclear]

[unclear]

[unclear]

[unclear]

[unclear]

[unclear]

[unclear]

[unclear]

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[unclear]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
13224  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13179

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela Springs - Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rhodesdale - Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maple S hade Convalescent Home</b>		d. STREET ADDRESS <b>Eldorado</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Elizabeth</b> Last <b>Payne</b>		4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 20, 1870</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Corkran</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Rhodes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Russel W. Hallowell, Federalsburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hemorrhage</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 2</b> to <b>Nov 2</b> 19 <b>60</b> , that (I) (we) lost saw the deceased alive on <b>Nov 2</b> 19 <b>60</b> , and that death occurred at <b>8A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>H. S. Kublman</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>H. S. Kublman</b>		22d. ADDRESS <b>Sharpton 2nd</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 4, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Eldorado Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Eldorado, Dorchester Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>		25. REC'D BY REGISTRAR DATE <b>NOV 9 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>			

# STATE DEPARTMENT OF HEALTH

1922

## CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>		<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>		<p>5. Place of death: _____</p>		<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>		<p>8. Signature of registrar: _____</p>		<p>9. Signature of informant: _____</p>	
<p>10. Name of informant: _____</p>		<p>11. Address of informant: _____</p>		<p>12. City and State: _____</p>	



8-4913180

## CERTIFICATE OF DEATH

Reg. Dist. No.

13199

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Life</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury Md</u> d. STREET ADDRESS <u>805 W. Main St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ella</u> First <u>Peters</u> Middle <u>Peters</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-11-1869</u>
9. AGE (In years last birthday) <u>90</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Wicomico</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dr. Liff Binkard</u>		14. MOTHER'S MAIDEN NAME <u>Joanne Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mary Correll</u>		Address <u>Salisbury Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>several yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 78 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 5, 1960</u> to <u>Nov. 23, 1960</u> that I last saw the deceased alive on <u>Nov. 19, 1960</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Herbert Sembly</u> M.D.		ADDRESS (Street, city or town, state) <u>400 E. Church St. Salisbury Md.</u> DATE SIGNED <u>Nov. 29, 60</u>	
PHYSICIAN'S NAME (Type) <u>G. Herbert Sembly</u>		<u>Salisbury Md.</u>	
22a. RURAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-27-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks M West</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>DEC 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a standard death certificate form with fields for name, age, date of death, and cause of death.]*

Name: \_\_\_\_\_  
Age: \_\_\_\_\_  
Date of Death: \_\_\_\_\_  
Cause of Death: \_\_\_\_\_  
Place of Death: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13200

CERTIFICATE OF DEATH

Items 7, 8, 9 Film 6275 11-28-60 et

13181

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 405 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 19x-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Norman Pusey		4. DATE OF DEATH Month Day Year Nov. 14 19 60					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 25, 1887	
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer		10b. KIND OF BUSINESS OR INDUSTRY farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Pusey		14. MOTHER'S MAIDEN NAME Margaret brown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs William H. Raurk Westover, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months 10 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 6, 1959, to Nov. 14, 1960, that (I) (we) last saw the deceased alive on Nov. 13, 1960, and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE Lee L. Lawry		22b. DATE 12:15 A.M. 11/14/60		22c. PHYSICIAN'S NAME (Type) Lee L. Lawry, M. D.			
22d. ADDRESS Deer's Head Hospital; Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 11-16-1960		23c. NAME OF CEMETERY OR CREMATORY Manokin Presbyterian		23d. LOCATION (City, town, or county) (State) Princess Anne, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lester R. Wilson		ADDRESS Princess Anne, Md.		25a. REC'D BY REGISTRAR NOV 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

GEN. DATE OF BIRTH

60581

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13182

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>139 Upton St</b>			d. STREET ADDRESS <b>139 Upton St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>SALLIE</b> Middle <b>JANE</b> Last <b>RUARK</b>			4. DATE OF DEATH Month <b>NOV.</b> Day <b>5th</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1886</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>8</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Sussex Co. Delaware</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>					
13. FATHER'S NAME <b>Johanthan C. Timmons</b>			14. MOTHER'S MAIDEN NAME <b>Sarah F. Short</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>			16. SOCIAL SECURITY NO. <b></b>		
17. INFORMANT <b>Mr. Charles W. Parker (Grand-son)</b>			Address <b>719 Rogers Street - Salisbury, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>generalized Carcinoma</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>carcinoma of uterus</b> DUE TO (c) <b></b>					INTERVAL BETWEEN ONSET AND DEATH <b>Noted 1959</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> 19 p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
20f. (City or town) <b>N/A</b>		20g. (County) <b></b>		20h. (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>October 8, 1960</b> to <b>November 5, 1960</b> that (I) <del>(we)</del> last saw the deceased alive on <b>Nov. 4, 1960</b> , and that death occurred at <b>8:45 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Robert T. Adkins</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <b>Nov. 7, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert T. Adkins</b>		22d. ADDRESS <b>Fruitland, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 8, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsonsborg Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Parsonsborg, Maryland</b>		23e. (State) <b></b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 9 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13183

13202 Item 2 Film 276 12-6-60 et

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>719 Rose Street</u> <u>Peninsula General Hospital</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First Middle Last		4. DATE OF DEATH <u>NOVEMBER 22 1960</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 18, 1941</u> 19 yrs.
9. AGE (In years last birthday) <u>19</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Sample</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Finey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Elizabeth Finey 719 Rose St Salisbury Md</u>	
17. INFORMANT <u>Elizabeth Finey 719 Rose St Salisbury Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dilatation of Rt Ventricle &amp; atrium.</u> <u>434.3</u> DUE TO <u>Hydro pericardium</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis - Trachea - bronchitis.</u> (c) <u>Coronary thrombosis - Trachea - bronchitis.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/22/60</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11/22/60</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>AC McIntire</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11/26/1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Church</u>		23d. LOCATION (City, town, or county) (State) <u>Stockton Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton C. Stewart</u>		25a. REC'D BY REGISTRAR <u>Salisbury Md</u>	
25b. REGISTRAR'S SIGNATURE <u>Clinton C. Stewart</u>		25c. DATE <u>DEC 2 '60</u>	





13302

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13185

13204

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Rt. 2</u> <u>23X-2</u>					
3. NAME OF DECEASED (Type or print) <u>Inf</u> First Middle Last				4. DATE OF DEATH <u>November 6 - 1960</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 5 - 1940</u>			
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>J</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Sheppard</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Lettie Sheppard</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>776X</u> IMMEDIATE CAUSE (a) <u>Prematurity - 740 grams -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>—</u> DUE TO (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11/5</u> 19 <u>60</u> to <u>11/6</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>11/6</u> 19 <u>60</u> and that death occurred at <u>—</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>William C Morgan</u>				M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>11-9-60</u>		<u>St James Cem</u>		<u>Salisbury, Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M West</u>				ADDRESS		25a. REC'D BY REGISTRAR			
DATE <u>2082161XV0</u>				DATE <u>NOV 14 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

1  
13205  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13186

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>W.</b> Last <b>Smith</b> <b>Somers</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> , Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR-15 1869</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Deal I. High School Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Smith Somers</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Lawes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>Deer's Head Hospital Records, Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary thrombosis</b> (c) <b>Arteriosclerosis general</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>9 hrs</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/14/60</b> 19 <b>60</b> , to <b>11/24</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Nov. 24th</b> 19 <b>60</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Juerman</b>		22b. DATE <b>11/25/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Juerman, M. D.</b>		22d. ADDRESS <b>Deer's Head State Hospital Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 27-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Deal Island Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>L. Webster</b>		25. REC'D BY REGISTRAR <b>NOV 29 '60</b>	
ADDRESS <b>Deal Island Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

13182

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND STATISTICS  
BOSTON

CERTIFICATE OF DEATH

13182

(3)

(4)

1. Name of deceased: John A. Smith

2. Sex: Male

3. Age: 45

4. Date of death: Jan 15 1918

5. Place of death: Home

6. Cause of death: Heart disease

7. Signature of physician: Dr. J. B. Brown

8. Signature of registrar: W. H. Green

9. Date of registration: Jan 16 1918

10. Place of registration: Boston

(5)

(6)

(7)

(8)

## CERTIFICATE OF DEATH

Reg. Dist. No.

13206

13187

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>45 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>700 Smith St.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARRIETT</b> Middle <b>ELLEN</b> Last <b>STEWART</b>				4. DATE OF DEATH Month <b>11</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-27-1881</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		10. UNDER 1 YEAR Months <b>11</b> Days <b>6</b> Hours <b>1960</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13. FATHER'S NAME <b>Joseph Washburn</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Pryor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-32-4170</b>			
17. INFORMANT <b>Mr. Frank M. Stewart, Same</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Arteriosclerosis (generalized)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>11-6</b> , 19 <b>60</b> , to <b>11-6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>11-6</b> , 19 <b>60</b> , and that death occurred at <b>74</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>11-7-60</b>							
ACTUAL SIGNATURE <b>Philip A. Insley</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley, 116 East Main St., Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-8-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Shad Point Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>	

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VS A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13207

CERTIFICATE OF DEATH

13188

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>704 East Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>L.</u> Last <u>SYKES</u>		4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 14, 1919</u>
9. AGE (In years lost birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Sykes</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Sarah Sykes 704 East Road Salisbury Md.</u>	
17. INFORMANT <u>Sarah Sykes</u>		Address <u>704 East Road Salisbury Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-28</u> <u>1960</u> to <u>11-8</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>10-8</u> <u>1960</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Carnie I. Earn</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>CARNIE I. EARN M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>11/12/1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>green acres</u>		23d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 18 '60</u>	
ADDRESS <u>Salisbury Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

CERTIFICATE OF DEATH

13202

1

John E. Stewart, M.D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13208

13189

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>WINFIELD</b> Last <b>TAYLOR</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>30th</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 10, 1886</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>20</b> Hours <b></b> Min. <b></b>	11. IF UNDER 24 HRS. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Owner &amp; Manager-Taylor Oil Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Quantico, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Wesley Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Georgia Hurley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs. Mary West Taylor (Wife)</b> Address <b>Ocean City Blvd Salisbury, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>444X Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b></b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>My hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days ? year</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> 19 p. m. <b></b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
20f. (City or town) <b>N/A</b> (County) <b></b> (State) <b></b>		21. I certify that (I) (this hospital) attended the deceased from <b>July 28, 1960</b> to <b>Nov 30, 1960</b> , that (I) <del>was</del> last saw the deceased alive on <b>Nov 30, 1960</b> , and that death occurred at <b>10:25 PM</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>Dr. Robert T. Adkins</b>		22b. DATE SIGNED <b>Dec. 3/1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert T. Adkins</b>		22d. ADDRESS <b>Fruitland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 3, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Allen Cemetery</b>		23d. LOCATION (City, town, or county) <b>Allen, Maryland</b> (State) <b></b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		25a. REC'D BY REGISTRAR <b>DEC 6 '60</b> DATE <b></b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. <b></b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13190

1. PLACE OF DEATH a. COUNTY <b>WICOMICO</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>				c. LENGTH OF STAY IN 1b <b>12 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PENINSULA GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>602 LINDEN AVENUE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELSIE G. THOMAS</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 4 1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 6, 1891</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>BENJAMIN WILLIAMS</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MR. OBED W. THOMAS, 602 LINDEN AVE. POCOMOKE CITY, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO <b>—</b> (c) <b>—</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/23</b> 19 <b>60</b> to <b>11/4</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>11/3</b> 19 <b>60</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>David J. Gilmore</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-5-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DAVID J. GILMORE, MD.</b>				22d. ADDRESS <b>SALISBURY, MARYLAND.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-6-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FIRST BAPTIST</b>		23d. LOCATION (City, town, or county) (State) <b>POCOMOKE CITY, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H. Watson</b>				ADDRESS <b>POCOMOKE CITY, MD.</b>		25a. REC'D BY REGISTRAR <b>NOV 8 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles E. Kraus</b>	

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CERTIFICATE OF DEATH

1920

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of death  
7. Cause of death  
8. Signature of physician  
9. Signature of registrar  
10. Date of registration

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13210

13191

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kiowa Ave.</b>				d. STREET ADDRESS <b>Kiowa Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edward</b>		First Middle Last <b>Twilley</b>		4. DATE OF DEATH <b>11-11-60</b>		Month Day Year <b>19</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 25, 1921</b>		9. AGE (In years last birthday) <b>39</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Twilley</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Jonson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Anna J. Price Kiowa Ave Salisbury Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>491X</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural cause</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b> M.D. EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md.</b> DATE SIGNED <b>11-18-60</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11/15/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>green acres</b>		22d. LOCATION (City, town, or country) (State) <b>Salisbury Md.</b>	
23. FUNERAL DIRECTOR <b>Clinton F. Stewart Salisbury Md</b>				24a. REC'D BY REGISTRAR <b>NOV 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Clinton F. Stewart</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13211  
CERTIFICATE OF DEATH  
13192

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>30</u> days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>23 X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>tyndall</u> Last <u>tyndall</u>		4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>85</u> yrs.
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>GEORGETOWN DEL</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MR. CHARLES COATES</u> Address <u>BERLIN MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cornea</u> DUE TO <u>Acute Retention of Urine</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Cystitis, Pyelitis</u> DUE TO <u>10 day</u> (c) <u>Unk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>not known</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 29</u> 19 <u>60</u> to <u>Nov 9</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Nov 9</u> 19 <u>60</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Herbert Sembly</u> M.D.		22b. DATE <u>11/9/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Herbert Sembly, M.D.</u>		22d. ADDRESS <u>400 E. Church St. Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/11/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>		23d. LOCATION (City, town, or county) <u>BERLIN MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burby</u> ADDRESS <u>Berlin Md</u>		25a. REC'D BY REGISTRAR <u>NOV 14 60</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

13110

CERTIFICATE OF DEATH

13111

1. Name of deceased  
2. Sex  
3. Age  
4. Date of death  
5. Place of death  
6. Cause of death  
7. Signature of physician  
8. Signature of registrar  
9. Date of registration  
10. Place of registration

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11. Name of informant  
12. Sex  
13. Age  
14. Date of birth  
15. Place of birth  
16. Cause of death  
17. Signature of informant  
18. Signature of registrar  
19. Date of registration  
20. Place of registration

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13193

13212

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sudlersville</b>	
c. LENGTH OF STAY IN lb <b>17 days</b>		d. STREET ADDRESS <b>17 x 2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Iola</b> Middle <b>Julia</b> Last <b>Warner</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>20</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1900</b>
9. AGE (In years last birthday) yrs. <b>60</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Del.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Pratt</b>		14. MOTHER'S MAIDEN NAME <b>Clementine Voshell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>221-20-4680</b>	
17. INFORMANT <b>Mrs. George Everett,</b>		Address <b>Sudlersville, Md.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Brain tumor</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 3, 1960</b> to <b>Nov. 20, 1960</b> that (I) (we) last saw the deceased alive on <b>Nov. 20, 1960</b> , and that death occurred at <b>7:05 P.M.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>L. V. Maldve, M. D.</b>		22b. DATE SIGNED <b>11/20/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22d. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 23, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Sudlersville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows, Millington, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 28 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Anthony S. Kraus</b>			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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Item 7 Film 275 11-22-60 et

13194

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>1015 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lena Elizabeth</b> Middle <b>Wheatley</b> Last <b>Wheatley</b>		4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 12, 1871</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months <b>89</b> Days <b>89</b> Hours <b>89</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gaifment operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US.</b>	
13. FATHER'S NAME <b>John S. Vickers</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ellis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Donald E. Wheatley, rhodesdale, md.</b>	
17. INFORMANT <b>Donald E. Wheatley, rhodesdale, md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, general</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 3, 1958</b> to <b>Nov. 15, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov. 15, 1960</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. V. Maldve, M. D.</b>		22b. DATE <b>11/15/60</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-19-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Church</b>		23d. LOCATION (City, town, or county) (State) <b>Deliance, Delaware</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Smith Funeral Home</b>		25a. REC'D BY REGISTRAR <b>NOV 18 '60</b>	
ADDRESS <b>Sharptown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

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1313

RECEIVED

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

13214

13195

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>Route #1</u>			
3. NAME OF DECEASED (Type or print) <u>Dwight</u> First <u>White</u> Middle Last				4. DATE OF DEATH <u>November 1</u> Month Day Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 30 - 1960</u>	
				9. AGE (In years, lost birthday) <u>2 days</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury md</u>	
13. FATHER'S NAME <u>Cristopher Pinder</u>				14. MOTHER'S MAIDEN NAME <u>Lettie White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Lettie White</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>760.0</u> IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage and Cerebral edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Acute and Chronic Fetal Anoxia</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 30th</u> 19 <u>60</u> to <u>Nov 1st</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 1st</u> 19 <u>60</u> , and that death occurred at <u>4:35</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>William C. Morgan</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-2-60</u>		<u>md Calvary</u>		<u>Frederick md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Booker McWest</u> ADDRESS				25a. REC'D BY REGISTRAR DATE <u>NOV 9 '60</u>		25b. REGISTRAR'S SIGNATURE <u>William C. Morgan</u>	

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CERTIFICATE OF DEATH

1891

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13225

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13196

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Parsonsburg</b>				c. LENGTH OF STAY IN 1b <b>X</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 1 (Wango)</b>				d. STREET ADDRESS <b>1 R.D.# 1 (Wango)</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>EDGAR</b> Middle <b>ALLEN</b> Last <b>WIMBROW</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Single</b> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 4, 1887</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Wico.Co. (Wango) Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Greensbury, Wimbrow</b>				14. MOTHER'S MAIDEN NAME <b>Lida Ellis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>W.W.# I</b>		17. INFORMANT <b>Miss Irma E. Wimbrow (Sister) R.D.# 1 (Wango) Parsonsburg, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction Coronary thrombosis</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis - Hypertension</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>Nov 6</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Nov 6</b> , 19 <b>60</b> , and that death occurred at <b>2:45 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Frank Lewis</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 7 / 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Frank R. Lewis</b>				22d. ADDRESS <b>Willards, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 9, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wango Cemetery - R.D.# Parsonsburg (Wango) Md.</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 9 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

BP

1000

CERTIFICATE OF DEATH

1000



## CERTIFICATE OF DEATH

13197

Reg. Dist. No.

13215

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Pleasant Nursing Home</b>				d. STREET ADDRESS <b>X Allen, Md.</b>			
3. NAME OF DECEASED (Type or print) First <b>Essie</b> Middle <b>Parks</b> Last <b>Windsor</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5 1881</b>		9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Parks</b>				14. MOTHER'S MAIDEN NAME <b>Mary Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Miss Rosa Windsor Allen, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X cerebral hemorrhage</b> DUE TO (b) <b>generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>? yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 28, 1960</b> , to <b>November 10, 1960</b> , that I last saw the deceased alive on <b>November 7, 1960</b> , and that death occurred at <b>2:10 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robt J. McKis</b> M.D.				ADDRESS (Street, city or town, state) <b>PRINCE ANNE, MD</b>		DATE SIGNED <b>Nov 11, 1960</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>11-12-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oriole Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oriole, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Levin R. Wilson</b>				ADDRESS <b>Princess Anne, Md</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 14 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13198											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allen</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. LENGTH OF STAY IN 1b <u>10 Years</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u> <u>Perry Smiths Farm</u>											
3. NAME OF DECEASED (Type or print) <u>John</u> <u>Winston</u>						4. DATE OF DEATH <u>11-11-60</u> <u>19</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> ?		8. DATE OF BIRTH		9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>				11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>						14. MOTHER'S MAIDEN NAME <u>?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>						16. SOCIAL SECURITY NO. <u>?</u>					
17. INFORMANT <u>Jackson Wallace, Allen, Md</u>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>?</u> (a), stating the underlying cause last. DUE TO (c) <u>?</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>?</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>II/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Freind Ship</u>		22d. LOCATION (City, town, or country) (State) <u>Allen, Maryland</u>	
23. FUNERAL DIRECTOR <u>William H. James Jr. Princess Anne, Md</u>						24a. REC'D BY REGISTRAR <u>NOV 21 '60</u>					
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>					

FOR FILE  
100-100000

18210

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Albino  
Albino  
Albino

Albino

Albino

11-11-60



Albino

Albino

11-11-60